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ABSTRACT

The Integrated Developmental Model (IDM) of supervision builds upon previous models of counselor and psychotherapist development. The IDM incorporates aspects of both a mechanistic view, using the machine as metaphor, and an organismic view, using the organism as metaphor, of development in describing trainee development through three levels and into a fourth or integrated level. Generally speaking, techniques and assumptions consistent with a mechanistic or behavioral orientation appear within each level of development as skills, knowledge, etc. combine in an additive manner. The overall model in describing change between levels of development more closely follows an organismic growth or qualitative change model. The IDM describes a trainee's progression through the developmental levels in terms of three basic structures: motivation, self- and other awareness, and autonomy. This progression is assumed to proceed in a relatively orderly fashion through various domains of functioning relevant to professional activities in counseling and psychotherapy. Eight domains are identified as important to professional development: intervention skills assessment; assessment techniques; interpersonal assessment; client conceptualization; individual differences; theoretical orientation; treatment goals and plans; and professional ethics. The added specificity of the IDM should be helpful to researchers and practitioners in testing the validity of its constructs. (ABL)

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THE INTEGRATED DEVELOPMENTAL MODEL OF SUPERVISION

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The Integrated Developmental Model of supervision (IDM) was proposed by Stoltenberg and Delworth in their 1987 book SUPERVISING COUNSELORS AND THERAPISTS. The IDM builds upon previous models of counselor and psychotherapist development including those proposed by Hogan (1964), Loganbill, Hardy, and Delworth (1982), and Stoltenberg (1981).

The IDM incorporates aspects of both a mechanistic view, using the machine as a metaphor, and an organismic view, using the organism as a metaphor, of development in describing trainee development through three levels which culminates in a fourth or integrated level. Generally speaking, techniques and assumptions consistent with a mechanistic or behavioral orientation appear within each level of development as skills, knowledge, etc. combine in an additive manner. The overall model in describing change between levels of development more closely follows an organismic growth or qualitative change model.

One of the more substantive contributions of the IDM over previous developmental models of training is its description of a trainee's progression through the developmental levels in terms of three basic structures:

Motivation

Self- and other awareness

Autonomy

This progression is assumed to proceed in a relatively orderly

fashion through various domains of functioning relevant to professional activities in counseling and psychotherapy. In each level, a structural shift occurs across domains. In the present model, eight domains are identified as important to professional development. Progress through stages within each domain is assessed by monitoring changes in the three primary structures. The final level is called Level 3 Integrated and is viewed as an integration of domains, which signifies attainment of the fully functioning stage of counselor and psychotherapist development. The eight domains are:

- Intervention skills competence
- Assessment techniques
- Interpersonal assessment
- Client conceptualization
- Individual differences
- Theoretical orientation
- Treatment goals and plans
- Professional ethics.

In our model, development is, in Loevinger's terms, "a bit loose and inconsistent" and follows her concept of amoeboid movement where an "island" of higher-level functioning expands until the new structure becomes predominant. Both vertical and horizontal development are stressed via Piaget's (1970) constructs of assimilation and accommodation. The trainee's progress within a domain (vertical) is monitored by changes in the structures while horizontal development occurs across domains. Although development is considered to be irreversible structural change, as

opposed to spiraling or recycling through the same stages over and over again, the model allows for brief regressions when trainees are faced with new or ambiguous tasks.

STRUCTURES

Before we move on to an example of how this process occurs within a given domain, let's look more closely at the three structures.

SELF- AND OTHER-AWARENESS

Level 1 - Trainee's primary focus is on him or herself, characterized by both cognitive and affective components, and not very insightful. Anxiety elicits self attention on skills performance and own discomfort (fears, uncertainty). This makes empathy very difficult.

Level 2 - Anxiety becomes less distracting and trainee can now focus more on the client's emotional and cognitive experience. In extreme cases, trainees may "lose themselves" in client's affect and perceptions of the world.

Level 3 - Empathy and understanding of the client is augmented by realization of client's impact on trainee. Can now move back and forth between focus on client, and insightful focus on self.

MOTIVATION

Level 1 - High motivation based on desire to learn and reduce anxiety. High desire to become a counselor and learn "correct" way of doing things.

Level 2 - Begins to sense that counseling and psychotherapy have limitations. Realization of own limitations and being less

protected by the supervisor results in fluctuating motivation.

Level 3 - Consistent motivation with understanding of own limitations and strengths. Therapeutic style is integrated with own individual identity.

AUTONOMY

Level 1 - Characterized by dependence on authority figures (supervisor). Leaves most important decisions up to supervisor regarding supervision and counseling. Devoted learner.

Level 2 - Initial success in counseling brings on stronger desire for some autonomous functioning. Dependency-autonomy conflict as trainee desires independence when confident and successful, and dependence when faced with stress or failure.

Level 3 - Successful resolution of this conflict results in a confident therapist able to function with relative autonomy; able to seek consultations and make appropriate referrals while keeping primary responsibility for the welfare of the client.

INTERPERSONAL INFLUENCE

I don't have sufficient time to go into any detail regarding how interpersonal influence, particularly using Petty and Cacioppo's Elaboration Likelihood Model of Persuasion (ELM; 1986), effects the supervision process. Suffice it to say for the present that the role of the supervisor changes as the trainee develops. In general, less teaching and structure are required as the trainee progresses, but different supervisory skills are necessary to actualize the growth potential for each level of trainee. The ELM serves to delineate how the supervisor can most effectively impact the trainee at each level by encouraging

Table 1. Client Conceptualizations and Treatment Plans.

Level 1

Self- and Other-Awareness—Emotional and cognitive self-focus. *Indications:* Diagnoses/conceptualizations will be "canned" or stereotypical, trying to fit clients into categories. Incomplete treatment plans will focus on specific skills or interventions, often quite similar across clients. Treatment plans may not reflect diagnoses.

Motivation—High, with strong desire to learn to become effective diagnostician and therapist. *Indications:* Willing student, will seek out additional information from books, colleagues, and other sources.

Autonomy—Dependent. *Indications:* Relies on supervisor for diagnoses and treatment plans. Locus of evaluation rests with supervisor.

Level 2

Self- and Other-Awareness—Emotional and cognitive focus on the client. *Indications:* Realizes treatment plan is necessary and logical extension of diagnosis. May resist "labeling" client into diagnostic classifications. Treatment plans may prove difficult due to lack of objectivity. May reflect various orientations yet lacks integration.

Motivation—Fluctuates depending upon clarity regarding various clients. *Indications:* May be pessimistic, overly optimistic or confident at times.

Autonomy—Dependency-autonomy conflict. *Indications:* May depend upon supervisor for diagnoses and treatment plans for difficult clients, may avoid or resist supervisor suggestions concerning others. Confident with some less confusing clients. More resistance to perceived unreasonable demands of supervisor, threats to tenuous independence and therapeutic self-esteem.

Level 3

Self- and Other-Awareness—Emotional and cognitive awareness of client and self. *Indications:* Able to "pull back" affectively and cognitively, monitor own reactions to client. The client's perspective and a more objective evaluation will be reflected in conceptualizations. Treatment plans will flow from diagnoses, taking into account client and environmental characteristics. Reflects therapist's own therapeutic orientation.

Motivation—Consistently high, based upon greater understanding of personality-learning theory and self. *Indications:* Not as susceptible to pessimism or undue optimism. Diagnoses and treatment plans consistently thought through and integrated.

Autonomy—Independent functioning. *Indications:* Seeks consultation when necessary. Open to alternative conceptualizations and treatment approaches but retains responsibility for decisions. Makes appropriate referrals.

intensive information processing and limiting potential resistance.

INTERACTIONS OF STRUCTURES AND DOMAINS

Let's look briefly at an example of how the structures interact with a couple of the domains we feel are important (see Table 1).

ADEQUACY OF THE IDM

We believe that the IDM provides significantly more detail in describing counselor development and predicting trainees' progression through the training process. Although I didn't have time to discuss it here, in our book we also detail how the various training environments (agencies, training programs, etc.) impact the trainee as he or she develops.

The added specificity of the IDM should be helpful to researchers and practitioners in testing the validity of its constructs. Both quantitative and qualitative work needs to be done to adequately evaluate the model. Hopefully, these constructs will be more easily operationalized and will result in better measures of counselor development.

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